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Multidrug-Resistant Tuberculosis in Hmong Refugees Resettling from Thailand into the United States, 2004–2005

In December 2003, the U.S. Department of State initiated a resettlement program for 15,707 Hmong refugees who had been displaced from Laos and were living on the grounds of Wat Tham Krabok, a Buddhist temple in Thailand. In January 2005, reports of tuberculosis (TB) cases among refugees still in Thailand and refugees who had arrived in the United States, including some cases caused by multidrug-resistant* (MDR) strains, prompted a 1-month travel suspension. After enhanced screening in Thailand and intensified TB-control measures in the United States, resettlement resumed on February 16. A majority of the Hmong refugees in Thailand and the United States with TB diagnosed were started on treatment and monitored. As of July 15, no additional TB cases had been diagnosed among newly resettled Hmong refugees. U.S. health departments should continue to ensure careful monitoring for TB among this refugee group.

Approximately 50,000–70,000 refugees resettle in the United States each year (*1*). Before resettlement, all refugees undergo medical screening to prevent importation of diseases that pose an immediate public health risk. The standard TB-screening algorithm, used in early 2004 to evaluate Hmong refugees in Thailand, includes a medical history and physical examination for all applicants and a chest radiograph for persons aged ≥15 years. Applicants with clinical or radiologic findings suggestive of TB disease submit three sputum specimens for acid-fast bacilli (AFB) smear microscopy. Those with positive results must begin anti-TB treatment and have follow-up specimens with consistently smear-negative results before travel to the United States is allowed.† The standard premigration algorithm was revised in May 2004 to add requirements for mycobacterial culture and drug-susceptibility testing.

During June 2004–January 2005, the United States resettled 9,459 Hmong refugees in 20 states (Table and Figure). As the newly arrived refugees underwent health assessments at local health departments and in private health-care facilities, 37 TB cases, including four MDR cases, were reported. This finding coincided with assessments in Thailand, where 17 (33%) of 52 culture-confirmed cases among refugees were determined to be MDR. In contrast, among all new TB cases reported in the United States during 2004 with drug-susceptibility results, 1% were MDR TB (*2*). Hmong refugee travel to the United States was suspended to allow for epidemiologic investigation and to prevent further importation of TB cases.

In January 2005, coordinated investigations were conducted in Thailand and the United States by the International Organization for Migration, CDC, the Thailand Ministry of Public Health, the U.S. Department of State, the U.S. Department of Health and Human Services Office of Global Health Affairs, and state and local health departments to describe the epidemiology of TB disease and to direct TB-control measures among the refugees. The case definition for TB disease required either 1) bacteriologic evidence (i.e., sputum-smear microscopy or culture) or 2) a decision to

*Defined as resistant to at least isoniazid and rifampin.

† *Medical Examination of Aliens*, 42 C.F.R. § 42; 2004.

INSIDE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

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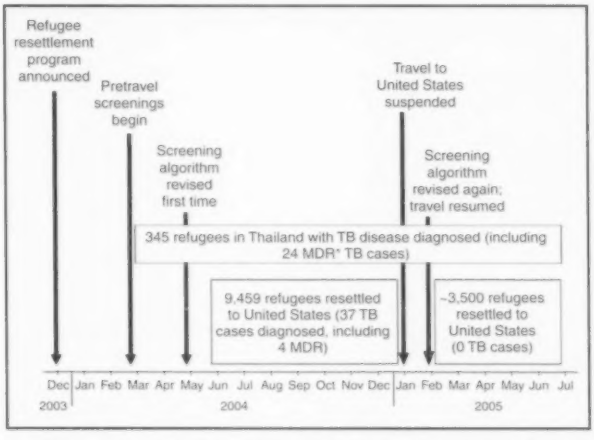
TABLE. Tuberculosis (TB) disease in Hmong refugees resettled from Thailand into the United States, by state — June 2004–January 2005

State	No. of Hmong refugees resettled	No. of Hmong refugees with TB disease diagnosed after resettlement*	No. of Hmong refugees with multidrug-resistant† TB diagnoses*
Minnesota	3,319	4	0
California	3,236	24	4
Wisconsin	2,139	7	0
Michigan	195	1	0
Ohio	44	1	0
15 other states§	526	0	0
Total	**9,459**	**37**	**4**

* As of July 15, 2005.
† Defined as resistant to at least isoniazid and rifampin.
§ Alaska, Arkansas, Colorado, Georgia, Illinois, Kansas, Massachusetts, Nebraska, North Carolina, Oklahoma, Oregon, Rhode Island, Texas, Virginia, and Washington.

FIGURE. Timeline for resettlement of Hmong refugees and identification of tuberculosis (TB) cases — Thailand and United States, December 2003–July 2005



* Multidrug-resistant. Defined as resistant to at least isoniazid and rifampin.

initiate TB treatment in the context of radiographic abnormalities or clinical features consistent with TB.

Thailand

The investigation in Thailand began with an evaluation of laboratory procedures, which excluded the possibility of false-positive culture results. Medical records of patients being treated for TB disease were reviewed, and all known patients were interviewed. Patient living quarters were mapped with global positioning system (GPS) technology to assess for potential geographic clustering of cases. Classmates of refugee children and other non-Hmong contacts were screened by chest radiograph and, if indicated, by sputum-smear microscopy.

During March 2004–January 2005, a total of 272 refugees, including 11 (4%) children aged <15 years, received a diagnosis of TB disease. Thirty (11%) of the 261 persons aged ≥15 years had AFB sputum-smear–positive pulmonary TB. One person tested positive for human immunodeficiency virus (HIV), 258 tested negative, and results for two persons were unknown. Children aged <15 years were not routinely tested for HIV. Medical records and interviews revealed that three (18%) of the 17 culture-confirmed MDR TB patients had been treated previously for TB disease. Nine (53%) reported at least weekly contact with another MDR TB patient, and seven were linked through a social network that centered around a patient with sputum-smear–positive MDR TB. GPS mapping revealed widespread distribution of TB cases throughout the Hmong living quarters in Wat Tham Krabok (an area of 0.5 km^2). No additional smear-positive TB cases were detected during screenings of classmates and other non-Hmong contacts in Thailand (n = 327).

In February 2005, the premigration screening algorithm for Hmong refugees was revised again. All refugees aged ≥6 months were rescreened with chest radiographs, and those aged 6 months to 10 years also underwent tuberculin skin testing. In addition, laboratory capacity was increased with addition of automated culture methods, access to MDR TB medications was ensured, and a team of physicians and nurses was established to provide expert case management for TB patients. Since the implementation of this enhanced algorithm, an additional 73 cases of TB disease have been diagnosed, including seven cases of MDR TB, resulting in an overall total of 345 TB cases (including 24 MDR). Patients are permitted to travel to the United States only after they have completed anti-TB treatment. As of July 15, a total of 341 Hmong refugees in Thailand had undergone treatment for TB disease under directly observed therapy, and 197 (58%) had completed treatment.

United States

Health departments in areas affected by the resettlement intensified surveillance for TB among the newly arrived refugees and continued providing diagnostic and treatment services for patients and their contacts. In addition, public health officials, resettlement agencies, and Hmong community organizations collaborated to determine educational needs and resources for sharing TB information with refugees and other members of the Hmong community in both Thailand and the United States.

California, where approximately one third of the refugees were resettled, reported 24 (65%) of the 37 TB cases, including 10 among children aged <15 years who, as directed by the initial screening algorithm, had not received a premigration TB screening. The 14 patients aged ≥15 years tested negative for HIV infection. Of the eight culture-confirmed cases in California, one (13%) had rifampin mono-resistance, and four (50%) were resistant to isoniazid, rifampin, ethambutol, and streptomycin. All four MDR TB patients had AFB sputum-smear–positive results. One MDR TB patient, who had initially tested rifampin-susceptible, acquired resistance to rifampin during treatment in Thailand. Local health departments have identified no secondary cases beyond immediate household members, although contact investigations continue.

Since resettlement resumed on February 16, approximately 3,500 additional Hmong refugees have been resettled to 22 states; none had TB diagnosed after arrival. Health departments continue to ensure that all recently arrived refugees are screened and treated for TB disease and infection when necessary. Health-care providers are asked to report to local and state health departments any additional TB cases detected in Hmong refugees who have arrived since June 2004.

Reported by: *International Organization for Migration, Geneva, Switzerland. Thailand Ministry of Public Health–US CDC Collaboration; Dept of Disease Control, Thailand Ministry of Public Health. Fresno County Dept of Community Health. Sacramento County Dept of Health and Human Svcs. California Dept of Health Svcs. Michigan Dept of Community Health. Minnesota Dept of Health. Ohio Dept of Health. Wisconsin Dept of Health and Family Svcs. Bur of Population, Refugees, and Migration, US Dept of State. Office of Global Health Affairs, US Dept of Health and Human Svcs. Div of Global Migration and Quarantine, National Center for Infectious Diseases; Div of Tuberculosis Elimination, National Center for HIV, STD, and TB Prevention, CDC.*

Editorial Note: The global incidence of TB disease is increasing (*3*), and an increasing percentage of TB cases in the United States are occurring among foreign-born persons (*2*). The Institute of Medicine has recommended that the United States strengthen its role in global TB-control activities, including enhancement of overseas TB screening and treatment capacity (*4*). The standard of care for TB case management includes high-quality diagnostic services and medications, consistent use of directly observed therapy, and standardized monitoring of outcomes. Emergence of MDR TB can be prevented by adhering to this standard.

The World Health Organization estimates that, when standard laboratory services are available and diagnostic criteria are applied, at least 65% of passively detected pulmonary TB cases among adults will have AFB smear-positive results (*5*). In this investigation, only 11% of the cases diagnosed among refugees aged ≥15 years awaiting resettlement were smear positive, suggesting that active surveillance might have led to overdiagnosis. Culture confirmation of 24 MDR cases in

Thailand and four MDR cases in the United States in the same refugee population within 16 months is cause for concern. Why the reported number of TB cases among resettled refugees was higher in California and why MDR TB cases among resettled refugees were found only in California remains unknown.

Because of the high prevalence of TB disease among the refugees described in this report, all are at risk for recent exposure to *Mycobacterium tuberculosis*. Recent infection is a major risk factor for progression to TB disease (*6*), but latent TB infection (LTBI) is not routinely treated in Thailand. Therefore, to prevent *M. tuberculosis* transmission and progression to TB disease in the United States, the domestic refugee health and TB programs affected by this resettlement should ensure postmigration monitoring and services for refugees, including treatment of LTBI.

These investigations and responses have required and will continue to demand considerable public health resources. Per person, the estimated costs of detecting disease and treating patients with LTBI range from $208 to $11,125, and the direct medical costs associated with TB and MDR TB disease range from $3,800 to $137,000, depending on case complexity.[§] These projections underestimate the costs for treating Hmong refugees because they exclude the additional expenses of providing culturally appropriate outreach, interpretation, and transportation services.

The annual number of immigrants to the United States continues to increase (*1*), and TB is the medical condition most frequently diagnosed among applicants for permanent residence (CDC, unpublished data, 2005). The number of imported TB cases described in this report would have been substantially greater if overseas screening had not been enhanced. For Hmong refugees resettling from Thailand, mycobacterial cultures and drug-susceptibility testing helped ensure appropriate treatment of patients with TB disease. These and other enhancements to standard premigration screening guidelines are under consideration for future U.S.-bound refugees and immigrants from other countries with a high TB burden.

[§] Estimated costs are derived from several studies (*7–10*). Direct medical costs of TB screening and treatment of LTBI caused by presumed isoniazid-susceptible strains are approximately $208–$311 per person without DOT. For each infected contact of a patient with MDR TB, California estimates follow-up and treatment costs to be $11,125 (T. Porco, California Department of Health Services TB Control Program, personal communication, 2005). If drug-susceptible TB disease is diagnosed, treatment costs are approximately $3,800 under daily DOT. Costs increase an additional $19,000 when patients require hospitalization, as do approximately 50%. Direct medical costs associated with MDR TB hospitalization average $53,000 and range from $15,000 to $137,000 per case. For each study, costs were updated to 2004 U.S. dollars by taking the costs determined by that study and multiplying them by the ratio of the medical-care component of the consumer price index for 2004, divided by the index for the year of the study, or, for costs dominated by personnel, a similar ratio of wages.

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Fatal Injuries Among Volunteer Workers — United States, 1993–2002

In the United States, an estimated 59 million persons spend a median of 52 hours each year volunteering, most often in religious, educational, youth, or community service organizations; volunteers commonly perform activities such as coaching, campaigning, fundraising, delivering goods, and serving on boards or neighborhood associations (*1*). Few studies have analyzed fatal injuries to volunteers, and studies have typically focused on a specific volunteer group (e.g., Peace Corps). To characterize fatal injuries among volunteers in the United States, CDC analyzed data from the Bureau of Labor Statistics (BLS) Census of Fatal Occupational Injuries (CFOI)* for 1993–2002. This report describes the results of that analysis, which indicated that a total of 501 persons died from injuries sustained while volunteering during this period; most often these persons were firefighters and other volunteers who were operating motor vehicles at the time of death. To reduce these fatalities, organizations that rely on volunteers need to

* By using death certificates, worker's compensation reports, state and federal agency records, and other supporting documents, CFOI collects data on all traumatic occupational fatalities in the 50 states and District of Columbia to determine worker demographics and the circumstances and causes of the fatality. CFOI data files provided to CDC do not include New York City.

provide adequate training (e.g., defensive driving and recognition of evacuation signals) on the basis of well-communicated and enforced safety and health policies.

CFOI classifies employee status into one of seven categories: 1) active-duty armed forces, 2) self-employed, 3) work in family business, 4) work for pay or compensation, 5) volunteer, 6) off-duty police, or 7) not reported. CFOI includes fatalities to volunteer workers if they were performing the same duties or functions as paid employees and they met the CFOI work-relationship definition.[†] For this study, deaths were included if the decedent's employment status category was marked "volunteer." Excluded were deaths resulting from the terrorist attacks of September 11, 2001. After numbers of deaths were obtained from CFOI, rates of death among volunteers were calculated by using estimates of median annual volunteer hours worked from the September 2002 Current Population Survey (CPS) volunteer supplemental survey[§] (*2*) and converting those hours to full-time equivalents (FTEs) (i.e., 2,000 hours worked per person per year). CPS defines a volunteer as a person who performed unpaid activities for an organization (*3*).

During 1993–2002, three occupations accounted for approximately half of the 501 fatal injuries to volunteers: firefighters, 185 deaths (37%); nonconstruction laborers, 35 (7%); and pilots/navigators, 24 (5%). The remaining fatalities (all ≤4%) were distributed across 13 occupations (Table 1). The single most common volunteer activity at the time of death was firefighting, for which 76 deaths (15%) were recorded. Driving a motor vehicle (e.g. automobile, truck, or farm vehicle) was recorded in 100 (21%) of the fatalities (Table 1). Under the system used by BLS to classify industry sectors, 240 (48%) deaths related to volunteer work occurred in public administration (including firefighting), 154 (31%) in services, and 23 (5%) in agricultural forestry and fishing. Median age of victims at the time of death was 41 years; 436 (87%) of the decedents were male.

The overall rate of death among volunteers was 3.2 per 100,000 FTE population (Table 2). Among 189 volunteer workers aged ≤34 years, 103 (54%) were volunteer firefighters or firefighting supervisors. The fatal injury rates for volunteer workers aged ≥35 years were lower when compared with the overall volunteer death rate. The rates among volunteers aged 20–24 and 25–34 years were 7.4 and 6.5 per 100,000 FTE population, respectively, more than twice the overall volunteer death rate and higher than the 1993–2002 average annual fatality rate for all workers aged 20–24 and 25–34 years of 3.5 and 3.9 per 100,000 employed, respectively (*2*).

TABLE 1. Number* and percentage of deaths among volunteer workers, by occupation and activity at time of death — Census of Fatal Occupational Injuries (CFOI),† United States, 1993–2002

Occupation/Activity	No.	%§
Occupation		
Firefighter	185	37
Nonconstruction laborer	35	7
Pilot/Navigator	24	5
Religious worker	19	4
Construction laborer	16	3
Truck driver	15	3
Farm worker	12	2
Groundskeeper	12	2
Protective services	8	2
Health technician	7	1
Personnel services	7	1
Athlete	6	1
Manager/Administrator	6	1
Firefighting supervisor	5	1
Sales supervisor	5	1
Nonclassifiable	7	1
Activity		
Driving	100	21
Truck	*49*	*10*
Automobile	*33*	*7*
Farm vehicle	*9*	*2*
Driving not elsewhere classified (NEC)	*9*	*2*
Fighting a fire	76	15
Riding (automobile or truck)	37	7
Operating (airplane)	22	4
Riding (airplane)	20	4
Walking in or near roadway	15	3
Rescuing or evacuating	15	3
Directing, flagging traffic	14	3
Installing	12	2
Walking	10	2
Repairing	7	1
Protective service activities	7	1
Standing	7	1
Tending an establishment, waiting on customers	7	1
Constructing, assembling	6	1
Driving, operating bicycle or motorcycle	5	1
Walking behind vehicle	5	1
Other (miscellaneous, not reported, NEC)	136	27

* N = 501. Occupations with <5 volunteer workers (n = 132) are not reported.
† By using death certificates, worker's compensation reports, state and federal agency records, and other supporting documents, CFOI collects data on all traumatic occupational fatalities in the 50 states and the District of Columbia to determine worker demographics and the circumstances and causes of the fatality. CFOI data files provided to CDC do not include New York City.
§ Percentages do not total to 100% because of rounding.

† Available at http://www.bls.gov/iif/oshcfdef.htm.

§ Current Population Survey (CPS), sponsored by the U.S. Census Bureau and BLS, is a multistage, stratified sample of approximately 60,000 households that provides current information on the labor force and demographic characteristics of the U.S. population. CPS includes the civilian, noninstitutionalized population aged ≥16 years. Response rate for the 2002 CPS survey was 92% (CPS, unpublished data, 2005). Volunteer supplemental surveys were conducted in 1989 and 2002–2004. This analysis used the 2002 volunteer survey to calculate rates. Response rate for the volunteer supplemental survey 2002 was 88% (CPS, unpublished data, 2005). Additional information is available at http://www.census.gov/prod/2002pubs/tp63rv.pdf.

TABLE 2. Fatal injuries to volunteer workers,* by age group and selected characteristics — Census of Fatal Occupational Injuries (CFOI),† United States, 1993–2002

Age group (yrs)	Volunteer deaths		Volunteers (in thousands)		Median annual hrs	Full-time equivalent (FTE) volunteers in 2002§	Rate per 100,000 FTE volunteers¶
	No.	(%)	No.	(%)			
≤15	12	(2)	—**	—	—	—	
16–19	27	(5)	4,346	(7)	40	86,920	3.1
20–24	47	(9)	3,515	(6)	36	63,270	7.4
25–34	103	(21)	9,279	(16)	34	157,743	6.5
35–44	86	(17)	15,089	(25)	52	392,314	2.2
45–54	81	(16)	12,296	(21)	53	325,844	2.5
55–64	54	(11)	7,146	(12)	60	214,380	2.5
≥65	85	(17)	7,492	(13)	96	359,616	2.4
Total	**495††**	**(99)**	**59,163**	**(100)**	**52**	**1,538,238**	**3.2**

* N = 501.
† By using death certificates, worker's compensation reports, state and federal agency records, and other supporting documents, CFOI collects data on all traumatic occupational fatalities in the 50 states and the District of Columbia to determine worker demographics and the circumstances and causes of the fatality. CFOI data files provided to CDC do not include New York City.
§ FTE = full time equivalent. (Median hours divided by 2000) multiplied by number of volunteers in 2002.
¶ ([Number of volunteer deaths during 1993–2002 multiplied by 100,000] divided by 10 years) divided by number of FTE volunteers.
** Not available.
††Age data for six cases were not available.

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Editorial Note: Certain volunteer work, such as firefighting, performing structural repairs, or collecting roadside litter can involve inherently hazardous duties or environments that increase the risk for injury or death. Volunteers engaged in this work might not be sufficiently aware of the dangers involved or any health and safety regulations associated with the work. In addition, supervisors of volunteers might not have the same authority as employers of paid persons to make certain that health and safety regulations are followed. The findings in this report indicate that 28% of all work-related volunteer fatalities occurred while driving or riding in a motor vehicle and that the decedents were most commonly firefighters. To reduce the risk for fatalities, driver training should be provided to volunteer firefighters as described in National Fire Protection Association standard 1451 (*4*). Other organizations using volunteer drivers should consider adopting policies and providing education that emphasizes safe driving at work (*5*) and in the community (*6*).

The findings in this report are subject to at least four limitations. First, CFOI might not capture all volunteer fatalities (i.e., deaths to volunteers in NYC or to persons involved in a motor-vehicle crash that might not have been identified as including a volunteer). Second, although the median number of hours worked by volunteers does not change substantially from year to year (*7*), calculation of death rates is based on the median hours of volunteer work reported from a single CPS volunteer supplemental survey (September 2002), which uses a sample of the U.S. population. Third, volunteer firefighters, although not typically paid for their work, might receive compensation such as reimbursement for annual medical exams or worker's compensation and retirement benefits. A state-by-state comparison of benefits is available at http://www.nvfc.org. Finally, occupation-specific fatality rates could not be calculated because volunteer occupations in the CPS survey are not categorized by using the same occupation definitions as CFOI.

Organizations that use volunteers should create or maintain policies that incorporate safety education and training into structured volunteer training and orientation. Organizations should designate persons with authority to identify and correct potential hazards and should monitor the activities of volunteers for adherence to their policies. All organizations, whether using volunteers or paid staff, should 1) identify risks and establish safety plans that include administrative measures for enforcement, 2) implement any necessary engineering controls, and 3) provide workers with any needed personal protective equipment (*8*). To identify risks to firefighters, CDC's National Institute for Occupational Safety and Health operates an ongoing Fire Fighter Fatality Investigation and Prevention Program that investigates deaths among firefighters, including volunteer firefighters.

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Interim Guidance for Minimizing Risk for Human Lymphocytic Choriomeningitis Virus Infection Associated with Rodents

On July 29, this report was posted as an MMWR Dispatch *on the* MMWR *website* (http://www.cdc.gov/mmwr).

In May 2005, CDC received reports of four organ-transplant recipients with unknown illness. All were discovered to have been infected with lymphocytic choriomeningitis virus (LCMV) via a common organ donor (*1*). Epidemiologic investigation traced the source of the virus to a pet hamster purchased by the donor from a local pet store. LCMV testing of other rodents at the pet store revealed three other LCMV-infected rodents (two hamsters and a guinea pig), supplied by a single distributor (distributor A). Preliminary laboratory testing of hamsters from distributor A has identified an infection rate of approximately 3% among the animals sampled. The facility of distributor A is under quarantine until it can be documented as free of LCMV infection. This report provides background information on LCMV and interim guidance* for the public on reducing risk for LCMV infection from pet rodents.

Background Information

LCMV is a rodent-borne arenavirus endemic in house mouse (*Mus musculus*) populations worldwide (*3–5*). Pet rodents (e.g., hamsters and guinea pigs) can become infected with LCMV after contact with wild rodents at a breeding facility, pet store, or home. The prevalence of LCMV in pet rodents is not known. Although other animals could possibly become infected with the virus, documented infections in humans have occurred only after exposure to infected mice, guinea pigs, and hamsters (*6,7*).

LCMV infection in humans with normal immune systems usually causes either asymptomatic or mild, self-limited illness, characterized by any or all of the following symptoms: fever, malaise, lack of appetite, muscle aches, headache, nausea, and vomiting. Aseptic meningitis also can occur in some patients, but the infection is rarely fatal (*6*). LCMV infection during the first or second trimester of pregnancy can cause severe illness or developmental defects in the fetus, including hydrocephalus, psychomotor retardation, and blindness (*8*); the proportion of developmental defects caused by LCMV is not known. Serologic studies of previous infection in humans in urban areas of the United States have demonstrated a prevalence of previous LCMV in those populations of approximately 5% (*3*).

Person-to-person transmission has not been associated with LCMV, except for transmission from mother to fetus or through organ transplantation (*1*). Human infection occurs most commonly through exposure (by direct contact or aerosol) to secretions or excretions of infected animals (*9*). LCMV infection is a well-known occupational risk for laboratory workers who work with LCMV-infected laboratory rodents (*9*).

An outbreak associated with pet hamsters sold by a single distributor was reported in 1974, when 181 symptomatic cases in persons with hamster contact were identified in 12 states; no deaths occurred (*10*). The outbreak was brought under control by voluntary cessation of sale and destruction of the infected breeding stock.

Control of Wild Rodents

Environmental modifications and hygiene practices that deter rodents from colonizing the home and work environment are the best means of reducing risk for exposure to infectious rodents. In addition, if rodents are found in work or living areas, safe practices for cleaning rodent waste and nesting materials are recommended. Preventing wild rodent entry also reduces opportunity for infection of pet rodents.

Detailed instructions on rodent-proofing, safe cleaning practices, and trapping wild rodents are available at http://www.cdc.gov/ncidod/dvrd/spb/mnpages/dispages/lcmv.htm.

* These recommendations were assembled by a CDC working group to provide interim guidelines for protection of public health. Guidelines for care of laboratory animals have been published previously (*2*). In addition, the National Association of State Public Health Veterinarians, in conjunction with partners, is developing a set of comprehensive veterinary infection-control guidelines.

General Recommendations for Preventing LCMV Infection from Pet Rodents

Hamsters and other rodents are common pets, and the number of documented human LCMV infections from pet hamsters and other rodents is low. Basic precautions can reduce the risk for acquiring LCMV and other infections from pet rodents. Because rodents might not always exhibit signs of ill health resulting from LCMV infection, CDC recommends taking appropriate precautions with any rodent:

- The public should be apprised of the risk for LCMV infection from rodents purchased from *any* pet store.
- Destruction or return of recently purchased pet rodents is not recommended. The probability of any one animal harboring LCMV infection is low. All pets are potential carriers of infectious diseases and should always be handled by using appropriate precautions.
- Pet rodents must not be released into the wild to prevent introduction of nonnative species to North America.
- Persons with specific concerns regarding the health of their pets should seek guidance from a veterinarian.

Purchasing a Healthy Pet

Information on purchasing a healthy pet and general steps to prevent pet rodents from bringing diseases into the home is available at http://www.cdc.gov/healthypets/lcmv_rodents.htm.

Care of Pet Rodents

Anyone handling or keeping pet rodents should take the following precautions to reduce the risk for LCMV infection:

- Wash hands with soap and water (or alcohol-based hand sanitizers when soap is unavailable and hands are not visibly soiled) after handling pet rodents or cleaning up pet droppings, cages, or areas where pets have been.
- Keep rodent cages clean and free of soiled bedding.
- Clean cages outdoors or in a well-ventilated area.
- Closely supervise young children when cleaning cages or handling rodents and supervise or assist children in washing their hands immediately after handling rodents and rodent cages or bedding.
- Never kiss or hold pet rodents close to the face.
- Never allow pet rodents to come into contact with wild rodents or their droppings or nests. Cover pet rodent cages and food supplies and always supervise pet rodents when they are not in their cages.

Precautions for Pregnant Women

Although the risk for LCMV infection from pet rodents is low, pregnant women or women who think they might become pregnant should be aware of the risks associated with LCMV infection during pregnancy. The following precautions can be taken to reduce the risk for acquiring LCMV infection during pregnancy:

- Avoid contact with wild rodents. Pregnant women who reside in a household with a wild rodent infestation should have the infestation addressed promptly by a professional pest control company or another member of the household.
- Keep pet rodents in a separate part of the home. Pregnant women should ask another family member or friend to clean the cage and care for the pet or arrange for temporary adoption of the pet by a responsible person. Pregnant women should avoid prolonged stays in any room where a rodent resides.

Precautions for Persons with Weakened Immune Systems

For the organ recipients described in this report, transplantation of LCMV-infected organs into persons with medically induced immunosuppression likely increased disease severity. Persons with impaired immune-system function should avoid contact with all rodents.

Testing for LCMV in Pet Rodents

CDC does not recommend testing pet rodents. Serologic testing on rodents can be inaccurate and misleading. All pet animals should be assumed capable of transmitting certain infectious diseases.

Testing for LCMV in Humans

Testing for LCMV infection in asymptomatic persons is not necessary. Similarly, testing persons with previous history of LCMV-compatible illness generally is not useful. Persons with active disease suggestive of LCMV should seek medical care and report any exposures to wild or pet rodents. A physician should determine whether testing for LCMV is indicated. Physicians should work closely with their respective state health departments to discuss forwarding of samples to state laboratories or CDC for testing.

Reported by: *Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases; EIS officer, CDC.*

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Tiered Use of Inactivated Influenza Vaccine in the Event of a Vaccine Shortage

The United States has experienced disruptions in the manufacture or distribution of inactivated influenza vaccine during three of the last five influenza seasons (*1–3*). Delays in delivery of influenza vaccine or vaccine shortages remain possible, in part, because of inherent time constraints in manufacturing the vaccine, given the annual updating of influenza vaccine strains and uncertainties regarding vaccine supply (including licensure of new vaccine preparations). Although total vaccine supply for the 2005–06 influenza season is not yet known, the minimum anticipated supply is approximately 58–60 million doses of inactivated vaccine and 3 million doses of live, attenuated vaccine. This estimated supply is similar to that available during the 2004–05 season and would be adequate to satisfy historical demand for influenza vaccine among persons considered by the Advisory Committee on Immunization Practices (ACIP) to be at high risk for serious complications associated with influenza virus infection, health-care workers, and household contacts of children aged <6 months (Table). These groups were prioritized for influenza vaccination in 2004–05 (*3*). Additional doses of inactivated influenza vaccine might be available for the U.S. market in

TABLE. Priority groups for vaccination with inactivated influenza vaccine and estimated vaccination coverage for 2003*

Tier	Priority group†	Population in 2003§ (millions)	Estimated vaccination coverage (%)	Estimated no. of persons vaccinated (millions)
1 A	Persons aged ≥65 years with comorbid conditions	18.2	70.9¶	12.9
	Residents of long-term–care facilities	1.7	80.0**	1.3
	Total	**19.9**	**71.4**	**14.2**
B	Persons aged 2–64 years with comorbid conditions	42.4	34.3††	14.5
	Persons aged ≥65 years without comorbid conditions	17.7	60.8¶	10.8
	Children aged 6–23 months	6.0	48.4††	2.9
	Pregnant women	4.0	12.8¶	0.5
	Total	**70.1**	**40.9**	**28.7**
C	Health-care personnel	7.0	40.1¶	2.8
	Household contacts and out-of-home caregivers of children aged <6 months	5.0	17.3††	0.9
	Total	**12.0**	**30.6**	**3.7**
2	Household contacts of children and adults at increased risk for influenza-related complications	70.3	18.2††	12.8
	Healthy persons aged 50–64 years	17.7	29.8¶	5.3
	Total	**88.0**	**20.6**	**18.1**
3	Persons aged 2–49 years without high-risk conditions	105.5	14.8¶	15.6

* Estimates are for 2003–04 season for most adult groups and the 2004–05 season for most pediatric groups because national influenza vaccination data on children were not available for 2003.
† Certain persons might be included in more than one group.
§ Based on 2003 population estimates from the U.S. Census Bureau.
¶ Based on the 2003 National Health Interview Survey (NHIS) for noninstitutionalized adults (CDC, unpublished data, 2005).
** Based on the 1999 National Nursing Home Survey (CDC, unpublished data, 2003).
†† Vaccination coverage for pediatric groups is based on estimates from the Behavioral Risk Factor Surveillance System (*MMWR* 2005;54:304–7). Vaccination coverage for adults is based on the 2003 NHIS.

2005–06, but this cannot yet be confirmed. Availability of additional vaccine would allow for expansion of the priority groups and, preferably, vaccination of all persons who desire it.

During periods of inactivated influenza vaccine shortfall, vaccination is prioritized on the basis of risk for serious influenza-associated complications. CDC and ACIP recommend use of vaccination priority groups only in the event of vaccine supply disruptions. At present, CDC and ACIP do not recommend prioritization of inactivated influenza vaccine for the 2005–06 season. Current recommendations for use of influenza vaccine were published recently (*4*). However, to help vaccine providers develop contingency plans for the upcoming influenza season in the event of a shortfall, this report details the priority groups for vaccination (Table). Announcement of a need for prioritization will be made promptly upon receipt of information indicating a potential disruption to the vaccine supply, if necessary.

ACIP and CDC determined the priority groups, ranked in three tiers, on the basis of influenza-associated mortality and hospitalization rates (Table). In the event of an influenza vaccine shortfall, persons in tier 1 should be vaccinated preferentially, followed by persons in tier 2, then persons in tier 3. On rare occasions when local vaccine supply is extremely limited, state and local health officials and vaccination providers should prioritize persons in group 1A before all other groups. However, in all other vaccine shortfall situations, persons in groups 1A, 1B, and 1C should be considered equivalent and should be vaccinated simultaneously. Eligible persons in group 1C and tiers 2 and 3 should be encouraged to receive live, attenuated influenza vaccine during periods of inactivated influenza vaccine shortfall.

References

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3. CDC. Interim influenza vaccination recommendations, 2004–05 influenza season. MMWR 2004;53:923–4.
4. CDC. Prevention and control of influenza: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2005;54(No. RR-8).

Notice to Readers

Applied Epidemiology Competency Development

CDC's Office of Workforce and Career Development and the Council of State and Territorial Epidemiologists (CSTE) have convened a panel to define competencies for applied epidemiology for local, state, and federal public health epidemiologists. This panel includes representatives of state and local public health agencies, academia, private industry, and CDC. The draft competency document for Tier 2 (i.e., mid-level) epidemiologists is now available for review and comment at http://www.cste.org/competencies.asp.

Practicing epidemiologists can review this document and submit comments online through September 16, 2005, at http://www.cste.org/assessment/competencies/index.asp. Persons and organizations employing applied epidemiologists can e-mail comments to competencies@cste.org. Competencies for Tier 1 (i.e., frontline) and Tier 3 (i.e., senior) epidemiologists will be available for comment in October 2005.

The panel will consider all information received and revise the competency documents for publication. Questions regarding competencies for applied epidemiology or the development process can be e-mailed to CSTE at competencies@cste.org.

Errata: Vol. 54, No. RR-8

In the *MMWR Recommendations and Reports*, "Prevention and Control of Influenza: Recommendations of the Advisory Committee on Immunization Practices (ACIP)," the following errors occurred:

On page 2, the fourth bullet should read, "The **2005–06** trivalent vaccine virus strains are A/California/7/2004 (H3N2)-like, A/New Caledonia/20/99 (H1N1)-like, and B/Shanghai/361/2002-like antigens."

On page 6, under the section "Children," the first sentence should read, "Children aged **≥6** months can develop protective levels of anti-influenza antibody against specific influenza virus strains after influenza vaccination (*69,70,78–81*), although the antibody response among children at high risk for influenza-related complications might be lower than among healthy children (*82,83*)."

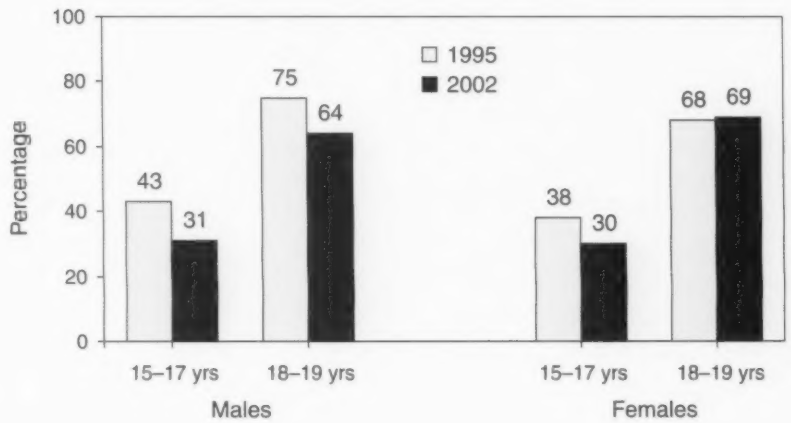
On page 18, under the section "LAIV Dosage and Administration," the fourth sentence should read, "Alternatively, the vaccine can be thawed in a refrigerator and stored at 2°C–8°C for **up to 60 hours** before use."

On page 20, under the section "Vaccination Before October," the last sentence should read, "For previously vaccinated children, **1 dose** is needed to provide optimal protection against influenza."

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

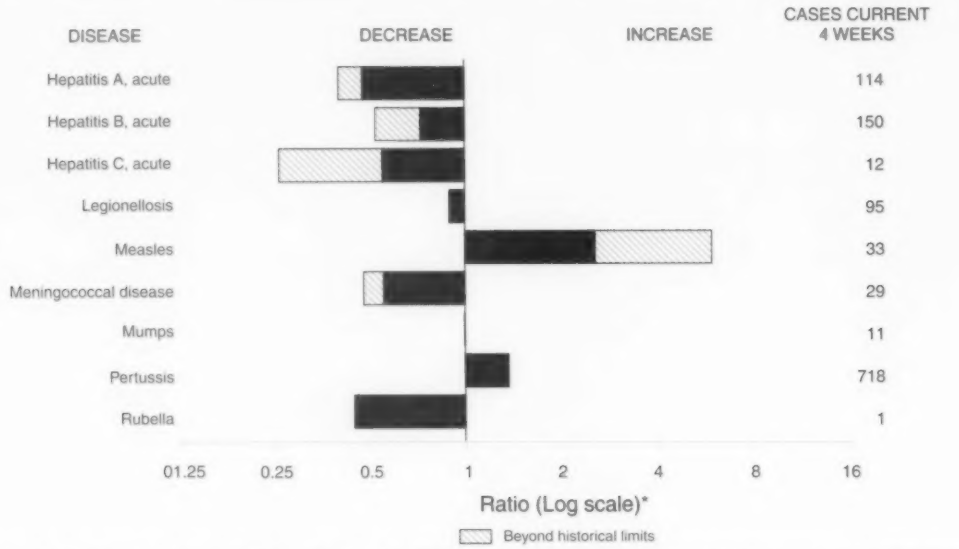
Percentage of Never-Married Teens Aged 15–19 Years Who Reported Ever Having Sexual Intercourse, by Sex and by Age Group — United States, 1995 and 2002



The percentage of male teens who reported ever having sexual intercourse decreased significantly for both younger (aged 15–17 years) and older (aged 18–19 years) teens from 1995 to 2002. Among females, the percentage who reported ever having sexual intercourse declined significantly for those aged 15–17 years. Additional information is available at http://www.cdc.gov/nchs/nsfg.htm.

SOURCES: 1995 and 2002 National Survey of Family Growth; 1995 National Survey of Adolescent Males; and Abma JC, Martinez GM, Mosher WD, Dawson BS. Teenagers in the United States: sexual activity, contraceptive use, and childbearing, 2002. Vital Health Stat 2004;23(24). Available at http://www.cdc.gov/nchs/data/series/sr_23/sr23_024.pdf.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals July 30, 2005, with historical data



* Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending July 30, 2005 (30th Week)*

Disease	Cum. 2005	Cum. 2004	Disease	Cum. 2005	Cum. 2004
Anthrax	—	—	Hemolytic uremic syndrome, postdiarrheal†	73	78
Botulism:			HIV infection, pediatric†¶	181	251
foodborne	7	6	Influenza-associated pediatric mortality†**	42	—
infant	30	45	Measles	55††	23§§
other (wound & unspecified)	15	8	Mumps	146	124
Brucellosis	50	54	Plague	2	—
Chancroid	13	17	Poliomyelitis, paralytic	—	—
Cholera	2	5	Psittacosis†	11	8
Cyclosporiasis†	613	164	Q fever†	60	39
Diphtheria	—	—	Rabies, human	1	2
Domestic arboviral diseases			Rubella	7	9
(neuroinvasive & non-neuroinvasive):	—	—	Rubella, congenital syndrome	1	—
California serogroup†§	2	50	SARS†**	—	—
eastern equine†§	2	1	Smallpox†	—	—
Powassan†§	—	1	*Staphylococcus aureus*:		
St. Louis†§	—	5	Vancomycin-intermediate (VISA)†	—	—
western equine†§	—	—	Vancomycin-resistant (VRSA)†	—	1
Ehrlichiosis:	—	—	Streptococcal toxic-shock syndrome†	83	96
human granulocytic (HGE)†	155	195	Tetanus	14	11
human monocytic (HME)†	114	130	Toxic-shock syndrome	56	50
human, other and unspecified †	27	33	Trichinellosis¶¶	10	1
Hansen disease†	42	58	Tularemia†	57	51
Hantavirus pulmonary syndrome†	15	14	Yellow fever	—	—

—: No reported cases.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).
† Not notifiable in all states.
§ Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNet Surveillance).
¶ Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention. Last update June 26, 2005.
** Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases.
†† Of 55 cases reported, 46 were indigenous and nine were imported from another country.
§§ Of 23 cases reported, seven were indigenous and 16 were imported from another country.
¶¶ Formerly Trichinosis.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending July 30, 2005, and July 31, 2004 (30th Week)*

Reporting area	AIDS		Chlamydia†		Coccidioidomycosis		Cryptosporidiosis	
	Cum. 2005§	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	20,405	23,315	497,963	524,919	2,345	3,112	1,144	1,552
NEW ENGLAND	778	769	17,200	17,418	—	—	64	93
Maine	11	14	1,188	1,129	N	N	9	14
N.H.	20	28	1,004	963	—	—	8	16
Vt.¶	4	13	539	658	—	—	14	12
Mass.	368	232	7,839	7,665	—	—	22	37
R.I.	68	82	1,747	1,924	—	—	2	2
Conn.	307	400	4,883	5,079	N	N	9	12
MID. ATLANTIC	4,352	4,995	62,593	64,751	—	—	152	248
Upstate N.Y.	800	653	12,380	12,766	N	N	45	53
N.Y. City	2,327	2,723	20,622	19,958	—	—	31	71
N.J.	574	919	9,329	10,369	N	N	10	22
Pa.	651	700	20,262	21,658	N	N	66	102
E.N. CENTRAL	1,938	1,901	76,161	91,477	5	7	245	427
Ohio	312	229	20,028	22,697	N	N	86	84
Ind.	236	246	10,970	10,276	N	N	17	40
Ill.	983	941	21,585	26,912	—	—	18	70
Mich.	322	380	13,207	20,831	5	7	36	76
Wis.	85	105	10,371	10,761	N	N	88	157
W.N. CENTRAL	463	470	29,405	32,044	4	5	181	203
Minn.	123	118	4,740	6,740	3	N	47	71
Iowa	50	36	3,345	3,881	N	N	40	37
Mo.	198	201	12,432	11,720	1	3	65	36
N. Dak.	5	14	603	1,090	N	N	—	8
S. Dak.	10	7	1,513	1,394	—	—	12	23
Nebr.¶	18	21	3,128	2,986	—	2	1	14
Kans.	59	73	3,644	4,233	N	N	16	14
S. ATLANTIC	6,473	7,144	95,611	97,759	—	—	240	252
Del.	100	102	1,792	1,617	N	N	—	—
Md.	812	804	10,218	10,756	—	—	14	10
D.C.	467	460	2,065	2,033	—	—	2	8
Va.¶	307	393	11,154	12,694	—	—	14	27
W. Va.	36	32	1,449	1,638	N	N	4	3
N.C.	531	390	18,599	15,979	N	N	29	43
S.C.¶	386	426	10,928	10,535	—	—	8	11
Ga.	1,103	1,011	15,448	18,081	—	—	53	80
Fla.	2,731	3,526	23,958	24,426	N	N	116	70
E.S. CENTRAL	1,093	1,163	36,420	34,280	—	4	36	62
Ky.	135	129	5,421	3,265	N	N	12	23
Tenn.¶	434	461	12,273	12,863	N	N	10	16
Ala.¶	295	286	7,235	7,869	—	—	13	13
Miss.	229	287	11,491	10,283	—	4	1	10
W.S. CENTRAL	2,206	2,954	61,822	67,301	1	2	29	56
Ark.	72	131	4,672	4,665	—	1	2	11
La.	436	590	10,801	14,107	1	1	3	—
Okla.	167	120	6,046	6,768	N	N	16	14
Tex.¶	1,531	2,113	40,303	41,761	N	N	8	31
MOUNTAIN	789	828	29,560	31,201	1,577	1,888	67	70
Mont.	4	4	1,121	1,486	N	N	12	14
Idaho¶	9	11	1,341	1,668	N	N	4	8
Wyo.	2	6	579	621	2	1	2	2
Colo.	163	162	7,788	7,617	N	N	22	27
N. Mex.	72	116	2,422	5,147	3	15	3	6
Ariz.	329	309	10,433	9,443	1,539	1,826	8	10
Utah	33	41	2,384	2,109	2	10	8	2
Nev.¶	177	179	3,492	3,110	31	36	8	1
PACIFIC	2,313	3,091	89,191	88,688	758	1,206	130	141
Wash.	229	213	10,596	10,022	N	N	10	—
Oreg.¶	136	155	4,783	4,744	—	—	23	20
Calif.	1,874	2,646	69,128	68,522	758	1,206	97	119
Alaska	14	21	2,258	2,149	—	—	—	—
Hawaii	60	56	2,426	3,251	—	—	—	2
Guam	1	1	—	686	—	—	—	—
P.R.	537	394	2,090	2,191	N	N	N	N
V.I.	10	6	32	226	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.

* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

† Chlamydia refers to genital infections caused by *C. trachomatis*.

§ Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention. Last update June 26, 2005.

¶ Contains data reported through National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending July 30, 2005, and July 31, 2004 (30th Week)*

Reporting area	*Escherichia coli*, Enterohemorrhagic (EHEC)						Giardiasis		Gonorrhea	
	O157:H7		Shiga toxin positive, serogroup non-O157		Shiga toxin positive, not serogrouped					
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	830	1,104	115	145	99	85	8,192	9,627	166,992	182,210
NEW ENGLAND	70	81	27	33	16	8	735	861	3,260	4,084
Maine	9	6	5	—	—	—	93	79	75	139
N.H.	8	12	1	5	—	—	35	23	93	66
Vt.	8	8	1	—	—	—	83	76	32	50
Mass.	25	37	6	11	16	8	300	391	1,458	1,801
R.I.	2	5	—	1	—	—	55	54	267	509
Conn.	18	13	14	16	—	—	169	238	1,335	1,519
MID. ATLANTIC	102	132	9	22	11	19	1,533	2,081	17,672	20,759
Upstate N.Y.	48	55	8	8	5	9	551	646	3,498	4,225
N.Y. City	3	26	—	—	—	—	389	623	5,355	6,400
N.J.	17	22	—	5	1	5	184	268	2,935	3,937
Pa.	34	29	1	9	5	5	409	544	5,884	6,197
E.N. CENTRAL	151	218	9	27	4	12	1,260	1,507	30,225	37,746
Ohio	49	49	1	6	2	10	350	420	9,253	11,608
Ind.	27	20	—	—	—	—	N	N	4,346	3,578
Ill.	14	44	1	2	—	2	256	447	8,725	11,484
Mich.	34	46	—	5	2	—	357	352	5,033	8,359
Wis.	27	59	7	14	—	—	297	288	2,868	2,717
W.N. CENTRAL	133	224	20	20	15	16	969	1,031	9,360	9,491
Minn.	21	48	6	8	4	2	469	344	1,334	1,658
Iowa	33	63	—	—	—	—	113	144	709	701
Mo.	43	42	9	10	6	6	210	295	5,031	4,859
N. Dak.	1	7	—	—	—	5	4	17	34	74
S. Dak.	6	18	2	—	—	—	37	34	207	150
Nebr.	11	30	3	2	3	—	48	73	753	608
Kans.	18	16	—	—	2	3	88	124	1,292	1,441
S. ATLANTIC	94	87	21	14	39	15	1,223	1,535	40,335	43,811
Del.	—	2	N	N	N	N	29	27	436	522
Md.	18	18	5	2	2	2	82	58	3,793	4,626
D.C.	—	1	—	—	—	—	22	42	1,111	1,433
Va.	11	16	9	6	8	—	255	229	3,862	5,160
W. Va.	1	1	—	—	—	—	18	17	398	505
N.C.	—	—	—	—	21	10	N	N	8,730	8,466
S.C.	2	7	—	—	—	—	57	59	4,634	5,176
Ga.	13	15	3	4	—	—	274	483	6,799	7,785
Fla.	49	27	4	2	8	3	486	620	10,572	10,138
E.S. CENTRAL	52	59	—	3	7	11	196	202	13,904	14,804
Ky.	13	14	—	1	6	7	N	N	1,773	1,416
Tenn.	21	24	—	—	1	4	99	107	4,325	4,740
Ala.	16	12	—	—	—	—	97	95	4,245	4,636
Miss.	2	9	—	2	—	—	—	—	3,561	4,012
W.S. CENTRAL	25	49	4	3	3	4	122	149	24,768	25,403
Ark.	4	10	—	—	—	—	39	64	2,420	2,342
La.	3	2	3	1	2	—	22	27	5,857	6,445
Okla.	11	10	—	—	—	—	61	58	2,443	2,859
Tex.	7	27	1	2	1	4	N	N	14,048	13,757
MOUNTAIN	79	99	23	22	4	—	622	744	5,963	6,228
Mont.	8	10	—	—	—	—	21	24	58	51
Idaho	9	22	8	3	2	—	47	91	52	47
Wyo.	1	2	2	1	—	—	12	13	30	31
Colo.	16	28	1	1	1	—	235	266	1,456	1,721
N. Mex.	3	7	3	4	—	—	25	45	446	649
Ariz.	19	9	N	N	N	N	82	102	2,240	1,996
Utah	14	12	9	12	—	—	164	146	362	320
Nev.	9	9	—	1	1	—	36	57	1,319	1,413
PACIFIC	124	155	2	1	—	—	1,532	1,517	21,505	19,884
Wash.	28	49	—	—	—	—	142	169	1,993	1,501
Oreg.	34	27	2	1	—	—	144	228	852	635
Calif.	49	74	—	—	—	—	1,159	1,034	17,892	16,622
Alaska	9	1	—	—	—	—	48	40	318	351
Hawaii	4	4	—	—	—	—	39	46	450	775
Guam	N	N	—	—	—	—	—	2	—	115
P.R.	—	—	—	—	—	—	26	122	198	160
V.I.	—	—	—	—	—	—	—	—	2	70
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending July 30, 2005, and July 31, 2004 (30th Week)*

Reporting area	*Haemophilus influenzae*, invasive							
	All ages		Age <5 years					
	All serotypes		Serotype b		Non-serotype b		Unknown serotype	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	1,292	1,239	3	9	68	68	123	115
NEW ENGLAND	97	114	—	1	8	7	3	1
Maine	5	7	—	—	—	—	1	—
N.H.	5	13	—	—	—	2	—	—
Vt.	6	5	—	—	—	—	2	1
Mass.	44	57	—	1	3	2	—	—
R.I.	7	3	—	—	2	—	—	—
Conn.	30	29	—	—	3	3	—	—
MID. ATLANTIC	253	260	—	1	—	3	31	28
Upstate N.Y.	73	88	—	1	—	3	5	4
N.Y. City	44	58	—	—	—	—	9	9
N.J.	47	47	—	—	—	—	8	2
Pa.	89	67	—	—	—	—	9	13
E.N. CENTRAL	185	231	1	—	2	8	10	34
Ohio	83	68	—	—	—	2	7	11
Ind.	47	35	—	—	2	4	—	1
Ill.	35	76	—	—	—	—	3	17
Mich.	13	15	1	—	—	2	—	3
Wis.	7	37	—	—	—	—	—	2
W.N. CENTRAL	73	63	—	2	3	3	9	5
Minn.	26	28	—	1	3	3	—	—
Iowa	—	1	—	1	—	—	—	—
Mo.	33	22	—	—	—	—	7	4
N. Dak.	1	3	—	—	—	—	1	—
S. Dak.	—	—	—	—	—	—	—	—
Nebr.	6	3	—	—	—	—	1	—
Kans.	7	6	—	—	—	—	—	1
S. ATLANTIC	314	283	1	—	20	19	17	20
Del.	—	—	—	—	—	—	—	—
Md.	45	46	—	—	5	5	—	—
D.C.	—	2	—	—	—	—	—	1
Va.	28	25	—	—	—	—	1	2
W. Va.	20	10	—	—	1	3	4	—
N.C.	58	40	1	—	7	5	—	1
S.C.	19	8	—	—	—	—	1	1
Ga.	60	80	—	—	—	—	7	15
Fla.	84	72	—	—	7	6	4	—
E.S. CENTRAL	74	48	—	1	1	—	12	7
Ky.	6	3	—	—	1	—	1	—
Tenn.	52	32	—	—	—	—	7	5
Ala.	16	12	—	1	—	—	4	2
Miss.	—	1	—	—	—	—	—	—
W.S. CENTRAL	74	48	1	1	5	6	6	1
Ark.	4	1	—	—	1	—	—	—
La.	28	9	1	—	2	—	6	1
Okla.	42	37	—	—	2	6	—	—
Tex.	—	1	—	1	—	—	—	—
MOUNTAIN	160	133	—	3	16	16	27	14
Mont.	—	—	—	—	—	—	—	—
Idaho	3	5	—	—	—	—	1	2
Wyo.	4	—	—	—	—	—	1	—
Colo.	31	32	—	—	—	—	6	3
N. Mex.	15	28	—	—	4	5	1	6
Ariz.	82	48	—	—	10	7	9	1
Utah	12	9	—	2	—	1	7	1
Nev.	13	11	—	1	2	3	2	1
PACIFIC	62	59	—	—	13	6	8	5
Wash.	1	1	—	—	—	—	1	1
Oreg.	24	29	—	—	—	—	5	2
Calif.	26	18	—	—	13	6	1	1
Alaska	4	5	—	—	—	—	1	1
Hawaii	7	6	—	—	—	—	—	—
Guam	—	—	—	—	—	—	—	—
P.R.	1	1	—	—	—	—	—	1
V.I.	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending July 30, 2005, and July 31, 2004 (30th Week)*

Reporting area	Hepatitis (viral, acute), by type					
	A		B		C	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	1,992	3,321	3,029	3,345	428	413
NEW ENGLAND	262	513	159	211	7	8
Maine	1	9	8	1	—	—
N.H.	52	13	12	23	—	—
Vt.	3	8	2	3	7	2
Mass.	172	432	114	105	—	6
R.I.	5	10	1	3	—	—
Conn.	29	41	22	76	U	—
MID. ATLANTIC	331	428	628	438	56	73
Upstate N.Y.	56	51	52	43	13	4
N.Y. City	162	174	58	85	—	—
N.J.	57	99	398	123	—	—
Pa.	56	104	120	187	43	69
E.N. CENTRAL	197	271	233	315	70	59
Ohio	31	32	81	71	2	4
Ind.	24	29	17	20	15	3
Ill.	45	85	37	50	—	12
Mich.	81	93	98	149	53	40
Wis.	16	32	—	25	—	—
W.N. CENTRAL	60	103	154	205	26	11
Minn.	3	28	14	27	3	8
Iowa	16	30	7	12	—	—
Mo.	28	21	98	130	21	3
N. Dak.	—	1	—	3	1	—
S. Dak.	—	2	1	—	—	—
Nebr.	3	10	17	20	1	—
Kans.	10	11	17	13	—	—
S. ATLANTIC	307	588	816	1,050	156	100
Del.	3	5	37	28	81	4
Md.	30	72	96	93	18	2
D.C.	2	4	6	13	—	2
Va.	48	50	90	120	8	11
W. Va.	3	1	22	18	9	16
N.C.	41	54	92	107	9	7
S.C.	16	33	78	83	2	12
Ga.	51	207	101	286	4	7
Fla.	113	162	294	302	25	39
E.S. CENTRAL	133	102	201	277	49	49
Ky.	12	17	36	31	4	19
Tenn.	94	70	76	136	11	14
Ala.	14	6	49	42	8	2
Miss.	13	9	40	68	26	14
W.S. CENTRAL	112	427	208	199	18	60
Ark.	4	53	21	73	—	1
La.	39	23	26	34	8	3
Okla.	4	17	19	41	—	3
Tex.	65	334	142	51	10	53
MOUNTAIN	187	254	296	251	23	23
Mont.	7	4	3	1	—	2
Idaho	15	12	7	6	—	1
Wyo.	—	4	1	7	—	—
Colo.	22	26	29	31	11	5
N. Mex.	9	15	7	10	—	U
Ariz.	114	159	198	127	—	4
Utah	13	26	30	23	6	2
Nev.	7	8	21	46	6	9
PACIFIC	403	635	334	399	23	30
Wash.	23	34	42	32	U	U
Oreg.	28	42	51	65	12	12
Calif.	337	539	231	289	11	17
Alaska	3	4	7	9	—	—
Hawaii	12	16	3	4	—	1
Guam	—	1	—	11	—	9
P.R.	14	27	10	52	—	—
V.I.	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending July 30, 2005, and July 31, 2004 (30th Week)*

Reporting area	Legionellosis		Listeriosis		Lyme disease		Malaria	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	736	943	307	362	5,777	9,308	572	779
NEW ENGLAND	38	26	16	14	446	1,473	31	63
Maine	3	—	—	3	25	29	3	6
N.H.	4	1	1	2	52	93	4	1
Vt.	1	1	1	—	9	20	1	3
Mass.	21	15	7	4	252	974	21	38
R.I.	3	2	2	1	3	84	2	2
Conn.	6	7	5	4	105	273	—	13
MID. ATLANTIC	216	225	71	87	3,878	5,994	149	205
Upstate N.Y.	59	42	25	23	919	1,699	26	24
N.Y. City	21	28	10	14	—	205	65	99
N.J.	44	35	13	22	1,454	1,741	38	48
Pa.	92	120	23	28	1,505	2,349	20	34
E.N. CENTRAL	130	233	32	65	334	799	45	71
Ohio	64	101	12	19	35	27	14	18
Ind.	10	23	1	14	6	5	—	7
Ill.	12	29	1	15	—	64	13	23
Mich.	33	64	12	15	12	8	14	14
Wis.	11	16	6	2	281	695	4	9
W.N. CENTRAL	37	24	11	6	187	145	28	44
Minn.	11	1	2	2	140	96	11	18
Iowa	3	3	4	1	28	18	4	2
Mo.	12	13	2	2	14	22	11	12
N. Dak.	1	1	2	—	—	—	—	3
S. Dak.	7	2	—	—	—	—	—	1
Nebr.	1	1	—	1	—	7	—	2
Kans.	2	3	1	—	5	2	2	6
S. ATLANTIC	175	202	70	54	822	800	130	173
Del.	10	3	N	N	323	120	2	4
Md.	43	38	11	7	373	509	51	37
D.C.	3	7	—	—	4	5	4	8
Va.	18	22	5	10	54	56	11	15
W. Va.	8	4	2	1	4	4	1	—
N.C.	16	20	13	13	27	63	16	11
S.C.	7	6	1	4	8	9	3	7
Ga.	12	30	13	10	—	11	17	36
Fla.	58	72	25	9	29	23	25	55
E.S. CENTRAL	34	56	14	18	20	25	13	21
Ky.	7	18	3	4	2	11	3	1
Tenn.	18	25	6	9	18	11	7	5
Ala.	8	12	4	3	—	3	3	11
Miss.	1	1	1	2	—	—	—	4
W.S. CENTRAL	16	93	13	25	35	21	36	85
Ark.	2	—	—	2	3	2	2	7
La.	4	5	6	2	3	2	2	4
Okla.	2	2	—	—	—	—	3	2
Tex.	8	86	7	21	29	17	29	72
MOUNTAIN	54	49	5	14	4	5	29	31
Mont.	4	1	—	—	—	—	—	—
Idaho	2	6	—	1	1	2	—	1
Wyo.	3	5	—	—	1	2	1	—
Colo.	15	10	2	5	—	—	16	11
N. Mex.	2	1	1	—	—	—	1	2
Ariz.	14	10	—	—	—	1	5	8
Utah	7	13	—	1	2	—	4	5
Nev.	7	3	2	7	—	—	2	4
PACIFIC	36	35	75	79	51	46	111	86
Wash.	—	5	6	6	1	3	8	5
Oreg.	N	N	4	5	9	19	3	12
Calif.	36	30	65	65	38	23	87	66
Alaska	—	—	—	—	3	1	3	—
Hawaii	—	—	—	3	N	N	10	3
Guam	—	—	—	—	—	—	—	—
P.R.	—	—	—	—	N	N	1	—
V.I.	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending July 30, 2005, and July 31, 2004 (30th Week)*

Reporting area	Meningococcal disease									
	All serogroups		Serogroup A, C, Y, and W-135		Serogroup B		Other serogroup		Serogroup unknown	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	745	798	54	64	38	32	—	1	653	701
NEW ENGLAND	52	48	1	5	—	5	—	1	51	37
Maine	2	9	—	—	—	1	—	—	2	8
N.H.	9	3	—	—	—	—	—	—	9	3
Vt.	5	2	—	—	—	—	—	—	5	2
Mass.	24	28	—	5	—	4	—	—	24	19
R.I.	2	1	—	—	—	—	—	—	2	1
Conn.	10	5	1	—	—	—	—	1	9	4
MID. ATLANTIC	95	114	27	33	4	5	—	—	64	76
Upstate N.Y.	24	33	3	5	3	3	—	—	18	25
N.Y. City	13	20	—	—	—	—	—	—	13	20
N.J.	27	22	—	—	—	—	—	—	27	22
Pa.	31	39	24	28	1	2	—	—	6	9
E.N. CENTRAL	71	86	15	19	7	5	—	—	49	62
Ohio	28	43	—	3	5	4	—	—	23	36
Ind.	13	14	—	1	2	1	—	—	11	12
Ill.	10	1	—	—	—	—	—	—	10	1
Mich.	15	15	15	15	—	—	—	—	—	—
Wis.	5	13	—	—	—	—	—	—	5	13
W.N. CENTRAL	50	51	2	—	1	4	—	—	47	47
Minn.	8	16	1	—	—	—	—	—	7	16
Iowa	12	11	—	—	1	2	—	—	11	9
Mo.	17	14	1	—	—	1	—	—	16	13
N. Dak.	—	1	—	—	—	—	—	—	—	1
S. Dak.	2	2	—	—	—	1	—	—	2	1
Nebr.	4	2	—	—	—	—	—	—	4	2
Kans.	7	5	—	—	—	—	—	—	7	5
S. ATLANTIC	141	152	4	2	7	2	—	—	130	148
Del.	2	2	—	—	—	—	—	—	2	2
Md.	15	8	2	—	2	—	—	—	11	8
D.C.	—	5	—	2	—	—	—	—	—	3
Va.	17	10	—	—	—	—	—	—	17	10
W. Va.	5	5	1	—	—	—	—	—	4	5
N.C.	21	24	1	—	5	2	—	—	15	22
S.C.	13	13	—	—	—	—	—	—	13	13
Ga.	13	9	—	—	—	—	—	—	13	9
Fla.	55	76	—	—	—	—	—	—	55	76
E.S. CENTRAL	38	37	1	1	3	—	—	—	34	36
Ky.	13	5	—	1	3	—	—	—	10	4
Tenn.	16	12	—	—	—	—	—	—	16	12
Ala.	5	10	1	—	—	—	—	—	4	10
Miss.	4	10	—	—	—	—	—	—	4	10
W.S. CENTRAL	59	47	1	1	5	1	—	—	53	45
Ark.	10	12	—	—	—	—	—	—	10	12
La.	24	27	—	1	2	—	—	—	22	26
Okla.	12	5	1	—	3	1	—	—	8	4
Tex.	13	3	—	—	—	—	—	—	13	3
MOUNTAIN	62	50	2	1	5	5	—	—	55	44
Mont.	—	3	—	—	—	—	—	—	—	3
Idaho	2	6	—	—	—	—	—	—	2	6
Wyo.	—	3	—	—	—	—	—	—	—	3
Colo.	13	12	2	—	—	—	—	—	11	12
N. Mex.	1	6	—	1	—	3	—	—	1	2
Ariz.	34	9	—	—	2	1	—	—	32	8
Utah	7	4	—	—	2	—	—	—	5	4
Nev.	5	7	—	—	1	1	—	—	4	6
PACIFIC	177	213	1	2	6	5	—	—	170	206
Wash.	31	19	1	2	4	5	—	—	26	12
Oreg.	25	42	—	—	—	—	—	—	25	42
Calif.	110	145	—	—	—	—	—	—	110	145
Alaska	1	2	—	—	—	—	—	—	1	2
Hawaii	10	5	—	—	2	—	—	—	8	5
Guam	—	—	—	—	—	—	—	—	—	—
P.R.	4	11	—	—	—	—	—	—	4	11
V.I.	—	—	—	—	—	—	—	—	—	—
Amer. Samoa	—	1	—	—	—	—	—	—	—	1
C.N.M.I.	—	—	—	—	—	—	—	—	—	—

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* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending July 30, 2005, and July 31, 2004 (30th Week)*

Reporting area	Pertussis		Rabies, animal		Rocky Mountain spotted fever		Salmonellosis		Shigellosis	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	9,735	8,018	2,788	3,573	604	663	17,305	20,836	6,029	7,141
NEW ENGLAND	545	930	399	323	3	11	1,082	1,067	130	151
Maine	13	4	31	35	N	N	81	55	5	5
N.H.	28	29	9	14	1	—	85	72	4	6
Vt.	62	46	37	11	—	—	60	33	6	2
Mass.	410	806	230	128	1	9	583	631	81	94
R.I.	12	16	8	20	1	1	45	48	9	9
Conn.	20	29	84	115	—	1	228	228	25	35
MID. ATLANTIC	756	1,441	319	488	34	46	2,100	3,213	591	729
Upstate N.Y.	283	1,034	260	252	2	1	576	602	158	308
N.Y. City	44	99	16	10	2	16	427	756	211	216
N.J.	133	103	N	N	12	9	337	582	167	141
Pa.	296	205	43	226	18	20	760	1,273	55	64
E.N. CENTRAL	2,022	2,429	65	55	17	20	2,226	2,820	382	574
Ohio	717	280	31	17	14	7	652	686	49	89
Ind.	172	52	5	5	—	4	257	236	39	93
Ill.	330	478	17	18	1	8	495	921	85	234
Mich.	120	73	12	13	2	1	443	449	134	63
Wis.	683	1,546	—	2	—	—	379	528	75	95
W.N. CENTRAL	1,411	685	229	368	103	66	1,208	1,287	701	217
Minn.	454	110	43	41	—	—	294	317	40	29
Iowa	341	49	36	41	1	1	179	259	45	43
Mo.	261	218	41	24	94	54	401	346	501	96
N. Dak.	77	256	13	41	—	—	17	20	2	2
S. Dak.	1	11	43	73	3	4	63	55	16	7
Nebr.	136	8	—	73	2	7	79	81	35	9
Kans.	141	33	53	75	3	—	175	209	62	31
S. ATLANTIC	685	377	951	1,361	280	326	4,699	5,024	995	1,768
Del.	5	—	—	9	2	4	49	51	6	5
Md.	104	70	171	173	35	29	383	464	39	74
D.C.	4	6	—	—	1	—	24	27	8	26
Va.	131	101	317	274	15	11	424	544	53	80
W. Va.	31	5	24	37	3	3	73	121	—	3
N.C.	64	49	292	371	176	174	659	570	99	172
S.C.	219	70	5	96	18	36	567	438	50	346
Ga.	25	15	135	196	19	56	643	938	244	399
Fla.	102	61	7	205	11	13	1,877	1,871	496	663
E.S. CENTRAL	280	126	80	77	105	83	1,083	1,287	774	435
Ky.	76	20	7	15	8	—	185	186	152	43
Tenn.	136	83	27	26	73	43	341	346	406	207
Ala.	47	13	46	28	23	22	312	331	168	151
Miss.	21	10	—	8	1	18	245	424	48	34
W.S. CENTRAL	376	360	549	704	32	96	1,349	2,007	1,302	1,966
Ark.	141	30	23	31	21	64	339	254	33	35
La.	24	11	—	—	5	4	355	442	60	201
Okla.	—	17	56	77	5	27	187	188	409	279
Tex.	211	302	470	596	1	1	468	1,123	800	1,451
MOUNTAIN	2,298	659	122	90	24	11	1,066	1,243	326	433
Mont.	433	18	3	14	1	3	48	78	5	4
Idaho	77	20	—	1	1	1	68	97	2	7
Wyo.	23	11	12	—	2	2	33	30	—	1
Colo.	784	325	11	17	3	2	269	307	53	75
N. Mex.	75	97	3	2	—	2	92	136	39	76
Ariz.	649	134	87	54	13	1	331	371	179	224
Utah	230	44	1	2	4	—	153	128	22	23
Nev.	27	10	5	—	—	—	72	96	26	23
PACIFIC	1,362	1,011	74	107	6	4	2,492	2,888	828	868
Wash.	365	368	U	U	—	—	246	240	45	56
Oreg.	422	273	3	3	—	2	182	253	37	38
Calif.	483	349	70	93	6	2	1,885	2,155	725	742
Alaska	22	11	1	11	—	—	28	33	6	5
Hawaii	70	10	—	—	—	—	151	207	15	27
Guam	—	—	—	—	—	—	—	45	—	36
P.R.	1	—	34	33	N	N	94	221	1	14
V.I.	—	—	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending July 30, 2005, and July 31, 2004 (30th Week)*

Reporting area	Streptococcal disease, invasive, group A		*Streptococcus pneumoniae*, invasive disease				Syphilis			
			Drug resistant, all ages		Age <5 years		Primary & secondary		Congenital	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	2,673	3,024	1,434	1,453	518	493	4,206	4,435	135	236
NEW ENGLAND	100	206	22	91	51	69	112	115	—	1
Maine	6	7	N	N	—	2	1	2	—	—
N.H.	8	15	—	—	3	N	7	3	—	—
Vt.	9	8	9	6	3	1	—	—	—	—
Mass.	70	92	—	24	45	39	80	72	—	—
R.I.	7	17	13	10	—	5	2	15	—	1
Conn.	—	67	U	51	U	22	22	23	—	—
MID. ATLANTIC	602	523	142	106	98	75	545	576	11	24
Upstate N.Y.	191	171	55	46	45	50	43	45	3	1
N.Y. City	102	79	U	U	17	U	341	350	5	9
N.J.	120	114	N	N	16	7	77	100	3	13
Pa.	189	159	87	60	20	18	84	81	—	1
E.N. CENTRAL	537	703	391	331	140	118	404	509	19	30
Ohio	133	165	245	233	58	56	120	131	2	2
Ind.	58	73	138	98	37	23	38	35	1	1
Ill.	113	194	8	—	41	1	178	210	6	5
Mich.	210	213	—	N	—	N	48	113	9	22
Wis.	23	58	N	N	4	38	20	20	1	—
W.N. CENTRAL	179	209	33	14	56	59	135	106	1	3
Minn.	64	104	—	—	33	38	32	17	—	1
Iowa	N	N	N	N	—	N	1	5	—	—
Mo.	52	44	27	11	5	9	85	61	1	1
N. Dak.	6	9	1	—	2	2	—	—	—	—
S. Dak.	16	9	3	3	—	—	—	—	—	—
Nebr.	13	14	2	—	6	6	3	5	—	—
Kans.	28	29	N	N	10	4	14	18	—	1
S. ATLANTIC	560	605	587	747	61	36	1,041	1,098	25	40
Del.	1	3	1	4	—	N	6	4	—	1
Md.	134	96	—	—	39	24	191	209	8	5
D.C.	7	5	14	7	2	4	67	34	—	1
Va.	48	50	N	N	—	N	66	62	3	2
W. Va.	17	17	85	82	20	8	2	3	—	—
N.C.	81	85	N	N	U	U	139	104	7	6
S.C.	22	47	—	77	—	N	30	72	2	10
Ga.	100	151	110	177	—	N	149	188	—	2
Fla.	150	151	377	400	—	N	391	422	5	13
E.S. CENTRAL	118	158	121	101	5	10	241	245	13	19
Ky.	23	50	21	22	N	N	22	26	—	1
Tenn.	95	108	100	77	—	N	107	78	9	7
Ala.	—	—	—	—	—	N	88	110	3	9
Miss.	—	—	—	2	5	10	24	31	1	2
W.S. CENTRAL	107	233	89	44	66	97	702	701	37	44
Ark.	11	12	12	6	13	7	29	29	—	3
La.	6	2	77	38	20	21	149	175	5	3
Okla.	76	44	N	N	17	28	22	19	1	2
Tex.	14	175	N	N	16	41	502	478	31	36
MOUNTAIN	411	329	49	18	34	29	218	225	15	29
Mont.	—	—	—	—	—	—	5	1	—	—
Idaho	1	6	N	N	—	N	18	13	1	2
Wyo.	2	6	20	6	—	—	—	1	—	—
Colo.	157	65	N	N	33	29	26	40	—	—
N. Mex.	26	72	—	N	—	—	27	56	2	2
Ariz.	173	154	N	N	—	N	80	94	12	25
Utah	51	24	28	10	1	—	4	5	—	—
Nev.	1	2	1	2	—	—	58	15	—	—
PACIFIC	59	58	—	1	7	—	808	860	14	46
Wash.	N	N	N	N	N	N	78	63	—	—
Oreg.	N	N	N	N	5	N	17	20	—	—
Calif.	—	—	N	N	N	N	705	773	14	46
Alaska	—	—	—	—	—	N	5	—	—	—
Hawaii	59	58	—	1	2	—	3	4	—	—
Guam	—	—	—	—	—	—	—	1	—	—
P.R.	N	N	N	N	—	N	102	80	6	3
V.I.	—	—	—	—	—	—	—	4	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending July 30, 2005, and July 31, 2004 (30th Week)*

Reporting area	Tuberculosis		Typhoid fever		Varicella (chickenpox)		West Nile virus disease†		
							Neuroinvasive		Non-neuroinvasive§
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005
UNITED STATES	5,510	7,418	117	164	14,065	13,491	31	417	70
NEW ENGLAND	169	232	13	16	971	1,914	—	—	—
Maine	9	12	1	—	206	180	—	—	—
N.H.	4	9	—	—	193	—	—	—	—
Vt.	4	1	—	—	34	410	—	—	—
Mass.	112	130	7	13	538	86	—	—	—
R.I.	14	28	1	1	—	—	—	—	—
Conn.	26	52	4	2	U	1,238	—	—	—
MID. ATLANTIC	1,109	1,136	29	40	2,958	67	1	3	3
Upstate N.Y.	132	147	5	4	—	—	—	—	1
N.Y. City	565	577	8	14	—	—	—	2	2
N.J.	257	244	9	12	—	—	—	—	—
Pa.	155	168	7	10	2,958	67	1	1	—
E.N. CENTRAL	723	666	8	17	3,959	4,035	3	8	—
Ohio	142	114	—	3	916	1,022	1	1	—
Ind.	70	71	—	—	120	N	1	2	—
Ill.	349	305	2	9	31	1	1	4	—
Mich.	118	129	3	4	2,609	2,527	—	1	—
Wis.	44	47	3	1	283	485	—	—	—
W.N. CENTRAL	225	265	3	7	232	134	4	15	19
Minn.	98	99	2	3	—	—	2	3	2
Iowa	20	19	—	—	N	N	—	2	—
Mo.	53	77	1	2	156	5	1	5	—
N. Dak.	2	3	—	—	12	74	—	1	—
S. Dak.	7	5	—	—	64	55	1	2	14
Nebr.	16	18	—	2	—	—	—	—	—
Kans.	29	44	—	—	—	—	—	2	3
S. ATLANTIC	1,247	1,539	18	23	1,268	1,595	—	17	—
Del.	2	17	—	—	21	4	—	—	—
Md.	151	145	6	9	—	—	—	—	—
D.C.	28	49	—	—	20	19	—	—	—
Va.	147	118	4	3	227	376	—	—	—
W. Va.	13	13	—	—	672	903	—	—	N
N.C.	126	153	2	3	—	N	—	1	—
S.C.	118	112	—	—	328	293	—	—	—
Ga.	195	358	2	3	—	—	—	2	—
Fla.	467	574	4	5	—	—	—	14	—
E.S. CENTRAL	311	324	3	6	—	4	1	18	2
Ky.	56	55	1	2	N	N	—	—	—
Tenn.	150	129	—	4	—	—	—	2	—
Ala.	105	107	1	—	—	4	—	8	—
Miss.	—	33	1	—	—	—	1	8	2
W.S. CENTRAL	476	1,181	3	12	2,997	4,213	4	37	2
Ark.	53	69	—	—	—	—	—	5	2
La.	—	—	—	—	104	47	1	17	—
Okla.	76	93	—	—	—	—	—	2	—
Tex.	347	1,019	3	12	2,893	4,166	3	13	—
MOUNTAIN	186	298	3	6	1,680	1,529	3	213	20
Mont.	6	4	—	—	—	—	—	—	—
Idaho	—	3	—	—	—	—	—	—	—
Wyo.	—	2	—	—	43	24	—	—	—
Colo.	37	76	—	1	1,190	1,207	—	19	10
N. Mex.	8	19	—	—	110	U	1	6	1
Ariz.	121	114	1	2	—	—	2	172	9
Utah	14	26	1	1	337	298	—	3	—
Nev.	—	54	1	2	—	—	—	13	—
PACIFIC	1,064	1,777	37	37	—	—	15	106	24
Wash.	130	135	3	3	N	N	—	—	—
Oreg.	54	54	2	—	—	—	—	—	—
Calif.	802	1,502	26	28	—	—	15	106	24
Alaska	15	20	—	—	—	—	—	—	—
Hawaii	63	66	6	6	—	—	—	—	—
Guam	—	38	—	—	—	88	—	—	—
P.R.	—	49	—	—	109	267	—	—	—
V.I.	—	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	—
C.N.M.I.	—	U	—	U	—	U	—	U	—

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.

* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

† Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNet Surveillance).

§ Not previously notifiable.

TABLE III. Deaths in 122 U.S. cities,* week ending July 30, 2005 (30th Week)

Reporting Area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45–64	25–44	1–24	<1	
NEW ENGLAND	434	292	101	22	11	6	46
Boston, Mass.	125	76	34	7	5	3	13
Bridgeport, Conn.	32	26	4	1	1	—	3
Cambridge, Mass.	17	10	2	2	—	1	3
Fall River, Mass.	25	16	7	1	1	—	3
Hartford, Conn.	44	33	8	2	1	—	3
Lowell, Mass.	24	15	4	3	2	—	1
Lynn, Mass.	6	6	—	—	—	—	1
New Bedford, Mass.	30	22	7	—	1	—	7
New Haven, Conn.	U	U	U	U	U	U	U
Providence, R.I.	5	3	2	—	—	—	1
Somerville, Mass.	6	4	2	—	—	—	—
Springfield, Mass.	32	15	13	4	—	—	1
Waterbury, Conn.	22	16	5	1	—	—	2
Worcester, Mass.	66	50	13	1	—	2	8
MID. ATLANTIC	1,959	1,307	442	128	48	32	96
Albany, N.Y.	51	32	10	7	1	1	5
Allentown, Pa.	19	16	3	—	—	—	—
Buffalo, N.Y.	68	46	20	—	1	1	8
Camden, N.J.	21	16	1	3	1	—	1
Elizabeth, N.J.	17	11	2	4	—	—	2
Erie, Pa.	26	17	8	1	—	—	1
Jersey City, N.J.	42	24	11	4	2	1	—
New York City, N.Y.	1,001	681	219	62	21	16	45
Newark, N.J.	42	21	13	7	—	1	2
Paterson, N.J.	11	6	4	1	—	—	—
Philadelphia, Pa.	340	211	87	24	12	6	13
Pittsburgh, Pa.§	21	16	5	—	—	—	—
Reading, Pa.	30	25	3	2	—	—	2
Rochester, N.Y.	101	69	19	3	6	4	6
Schenectady, N.Y.	13	9	2	1	1	—	2
Scranton, Pa.	33	28	3	2	—	—	—
Syracuse, N.Y.	54	33	15	3	2	1	7
Trenton, N.J.	29	19	8	2	—	—	—
Utica, N.Y.	15	12	2	1	—	—	—
Yonkers, N.Y.	25	15	7	1	1	1	2
E.N. CENTRAL	1,875	1,229	426	125	49	45	81
Akron, Ohio	30	23	5	—	2	—	3
Canton, Ohio	28	18	8	2	—	—	2
Chicago, Ill.	304	170	94	27	7	6	14
Cincinnati, Ohio	32	22	5	4	1	—	1
Cleveland, Ohio	227	167	45	9	2	4	—
Columbus, Ohio	209	137	45	17	5	5	12
Dayton, Ohio	128	88	28	8	3	1	8
Detroit, Mich.	158	84	44	16	8	6	10
Evansville, Ind.	50	38	9	2	—	1	1
Fort Wayne, Ind.	57	37	14	3	1	2	2
Gary, Ind.	8	4	1	1	2	—	—
Grand Rapids, Mich.	57	39	11	2	4	1	5
Indianapolis, Ind.	172	107	37	15	3	10	9
Lansing, Mich.	39	32	4	1	1	1	—
Milwaukee, Wis.	110	73	23	5	4	4	7
Peoria, Ill.	39	20	14	2	2	1	1
Rockford, Ill.	38	24	8	2	2	2	2
South Bend, Ind.	43	36	4	2	—	1	1
Toledo, Ohio	90	64	19	5	2	—	2
Youngstown, Ohio	56	46	8	2	—	—	1
W.N. CENTRAL	635	408	149	43	18	17	21
Des Moines, Iowa	108	76	24	5	3	—	2
Duluth, Minn.	31	20	8	3	—	—	2
Kansas City, Kans.	21	13	5	3	—	—	—
Kansas City, Mo.	102	62	25	6	4	5	3
Lincoln, Nebr.	28	19	5	2	—	2	2
Minneapolis, Minn.	58	38	11	6	1	2	3
Omaha, Nebr.	73	44	17	6	4	2	2
St. Louis, Mo.	78	37	28	8	2	3	4
St. Paul, Minn.	62	42	14	3	1	2	3
Wichita, Kans.	74	57	12	1	3	1	—
S. ATLANTIC	1,167	711	303	91	35	24	68
Atlanta, Ga.	142	91	37	11	1	2	6
Baltimore, Md.	135	71	36	22	5	—	16
Charlotte, N.C.	102	62	28	7	—	4	10
Jacksonville, Fla.	137	84	31	15	6	1	6
Miami, Fla.	114	82	22	7	2	1	2
Norfolk, Va.	56	29	21	1	2	3	4
Richmond, Va.	53	19	18	5	7	4	1
Savannah, Ga.	59	35	11	5	1	7	3
St. Petersburg, Fla.	54	38	13	2	—	1	3
Tampa, Fla.	201	135	47	12	6	—	14
Washington, D.C.	100	54	36	4	5	1	3
Wilmington, Del.	14	11	3	—	—	—	—
E.S. CENTRAL	686	436	173	43	13	21	45
Birmingham, Ala.	161	105	31	15	5	5	14
Chattanooga, Tenn.	78	46	30	1	1	—	6
Knoxville, Tenn.	93	60	20	11	1	1	2
Lexington, Ky.	73	44	19	4	1	5	6
Memphis, Tenn.	U	U	U	U	U	U	U
Mobile, Ala.	104	69	27	3	1	4	3
Montgomery, Ala.	32	25	7	—	—	—	4
Nashville, Tenn.	145	87	39	9	4	6	10
W.S. CENTRAL	1,454	905	342	110	52	45	60
Austin, Tex.	97	64	18	8	4	3	5
Baton Rouge, La.	9	9	—	—	—	—	3
Corpus Christi, Tex.	57	41	12	2	1	1	2
Dallas, Tex.	188	99	58	17	6	8	8
El Paso, Tex.	92	65	13	7	5	2	1
Ft. Worth, Tex.	118	67	22	14	7	8	5
Houston, Tex.	332	201	85	25	11	10	18
Little Rock, Ark.	80	51	22	4	3	—	2
New Orleans, La.	89	44	27	9	6	3	5
San Antonio, Tex.	247	169	51	14	8	5	6
Shreveport, La.	44	27	9	6	1	1	—
Tulsa, Okla.	101	68	25	4	—	4	5
MOUNTAIN	896	568	201	64	29	31	50
Albuquerque, N.M.	102	70	22	9	1	—	3
Boise, Idaho	48	40	7	—	1	—	2
Colo. Springs, Colo.	52	41	7	2	1	1	—
Denver, Colo.	103	50	29	10	5	9	3
Las Vegas, Nev.	250	156	64	16	8	6	19
Ogden, Utah	45	30	8	3	2	2	2
Phoenix, Ariz.	168	104	36	11	6	8	9
Pueblo, Colo.	23	16	6	—	1	—	2
Salt Lake City, Utah	105	61	22	13	4	5	10
Tucson, Ariz.	U	U	U	U	U	U	U
PACIFIC	1,458	968	321	104	44	21	112
Berkeley, Calif.	13	7	4	2	—	—	3
Fresno, Calif.	129	89	26	7	6	1	15
Glendale, Calif.	4	4	—	—	—	—	1
Honolulu, Hawaii	64	46	16	2	—	—	5
Long Beach, Calif.	63	44	15	2	—	2	5
Los Angeles, Calif.	112	81	16	8	4	3	14
Pasadena, Calif.	37	27	4	4	1	1	4
Portland, Oreg.	122	79	30	9	4	—	3
Sacramento, Calif.	224	146	45	22	9	2	14
San Diego, Calif.	142	92	34	11	2	3	12
San Francisco, Calif.	106	63	32	9	1	1	10
San Jose, Calif.	165	111	34	8	9	3	14
Santa Cruz, Calif.	23	18	3	2	—	—	2
Seattle, Wash.	109	61	33	10	3	2	3
Spokane, Wash.	52	42	7	2	1	—	2
Tacoma, Wash.	93	58	22	6	4	3	5
TOTAL	10,564¶	6,824	2,458	730	299	242	579

U: Unavailable. —: No reported cases.

* Mortality data in this table are voluntarily reported from 122 cities in the United States, most of which have populations of ≥100,000. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

† Pneumonia and influenza.

§ Because of changes in reporting methods in this Pennsylvania city, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

¶ Total includes unknown ages.

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